



A Dr. Hallowell Protocol
SHINE *for* Doctors

Special Help Integrating Neurological Experience™

Name of Patient		Date	
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	/ / Age
Address			
Address		Phone Number	
Parent(s) Name			Age
Education Level Attained			
Parent(s) Name			Age
Education Level Attained			
Legal Guardian			
Person completing form			

FAMILY HISTORY

Family history can often be helpful in understanding a child's problems.

Please check any box that applies:

<i>Has anyone in the family had:</i>	<i>Siblings</i>	<i>Parents</i>	<i>Extended Family</i>
Motor problems			
Reading problems			
Speech/language problems			
School/learning problems			
Alcohol/drug problems			
Anxiety, depression, other psychological disorders			
Seizures/epilepsy			
Attention problems/hyperactivity			

Please list all family members (in or out of house) and other people currently in the house:

NAME	RELATIONSHIP	AGE	CURRENTLY IN HOUSE?

Parents are: Married Living together Divorced Separated Widowed

BIRTH HISTORY

How would you describe your pregnancy? _____

Did you experience complications? If so, please list: Example, Gestational Diabetes, Pre-eclampsia, high blood pressure etc? _____

Did you receive any vaccinations while pregnant? Yes No

Was any dental work done while pregnant? Yes No If yes, what? _____

Did any stressful situations occur during pregnancy? Example, death in the family, loss of spouse's job, separation, etc? _____

Please check what best describes your labour and birth of your child?

- | | | |
|---|--|--|
| <input type="checkbox"/> Normal (no interventions) | <input type="checkbox"/> Rh Factor problems | <input type="checkbox"/> Caesarian section |
| <input type="checkbox"/> Mother was sick | <input type="checkbox"/> Long/difficult labour | <input type="checkbox"/> Forceps or suction used |
| <input type="checkbox"/> Complications during birth | <input type="checkbox"/> Epidural given | <input type="checkbox"/> Induced |
| <input type="checkbox"/> Problems with the umbilical cord | <input type="checkbox"/> Facial/ breech/ brow presentation | |

Did your child have any of the following problems at birth:

- | | | |
|---|--|---|
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Infection |
| <input type="checkbox"/> Low birth weight | <input type="checkbox"/> Problems with bones/joints | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Fever or seizures | <input type="checkbox"/> Required blood transfusions | <input type="checkbox"/> Intensive care |
| <input type="checkbox"/> Bruised anywhere | <input type="checkbox"/> Nerve Problems | |

Does this/ did this child have any birth defects? Yes No

If yes, list: _____

Describe what your child's temperament was like as an infant.

- | | | | |
|------------------------------------|---------------------------------|--|--|
| <input type="checkbox"/> Difficult | <input type="checkbox"/> Calm | <input type="checkbox"/> Sleepy | <input type="checkbox"/> Hyper sensitive |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Active | <input type="checkbox"/> Easily scared | <input type="checkbox"/> Frequent crying |
| <input type="checkbox"/> Sociable | <input type="checkbox"/> Cranky | <input type="checkbox"/> Happy | <input type="checkbox"/> Alert |

During the first twelve months, was this child:

- | | | | |
|-----------------------------------|--|---------------|--|
| Difficult to get to sleep | <input type="checkbox"/> Yes <input type="checkbox"/> No | Irritable | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Difficult to be put on a schedule | <input type="checkbox"/> Yes <input type="checkbox"/> No | Alert | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Easy to comfort | <input type="checkbox"/> Yes <input type="checkbox"/> No | Affectionate | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Overactive/in constant motion | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sociable | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Was the child breast fed? | <input type="checkbox"/> Yes <input type="checkbox"/> No | For how long? | _____ |

When was solid food introduced? _____

Was there any evidence of food intolerances? Yes No

If so, to what? _____

DEVELOPMENTAL HISTORY:

How old was the child when (s)he:

	Average Age	Approximate Age	If not sure, please estimate		
Sat	4-7 mos		Early	Average	Late
Walked	12-17 mos		Early	Average	Late
Toilet Trained	18-36 mos		Early	Average	Late
Said first words	12-17 mos		Early	Average	Late
Began using sentences	36-60 mos		Early	Average	Late

SPEECH AND LANGUAGE

Has his/her hearing ever been tested? Yes No

Does this child have a history of frequent ear infections? Yes No

Has (s)he ever had tubes placed in her/his ears? Yes No

Last hearing/audiology evaluation: PLACE _____ DATE: _____

Does this child have:

Any speech problems/difficulty speaking? Yes No

Have trouble understanding what is being said to him/her? Yes No

Has (s)he ever had a Speech and Language Evaluation? Yes No

If yes, where? _____ When? _____

RESULTS _____

Has (s)he ever had Speech/Language Therapy? Yes No

Is (s)he currently receiving Speech/Language Therapy? Yes No

If yes, where? _____ Frequency: _____

MOTOR SKILLS

Does this child have fine motor problems (writing, drawing)? Yes No

Has (s)he ever had Occupational Therapy (OT) evaluation? Yes No

Is (s)he currently receiving OT services? Yes No

If yes, where? _____ Frequency: _____

Does (s)he have any gross motor problems (walking, running)? Yes No

Has (s)he ever had a Physical Therapy (PT) evaluation? Yes No

Is (s)he currently receiving PT services? Yes No

If yes, where? _____ Frequency: _____

Does this child use any adaptive devices (braces)? Yes No

If yes, please describe: _____

VISION

Has this child ever been to an eye doctor? Yes No

Most recent date: _____

Does this child wear glasses? Yes No

If yes, why? _____

Has this child ever been assessed for / diagnosed with:

- | | |
|---|--|
| <input type="checkbox"/> Binocular Vision | <input type="checkbox"/> Convergence Insufficiency |
| <input type="checkbox"/> Other Convergence Issues | <input type="checkbox"/> Fixation Issues |

IMPORTANT: if a child wears glasses, please bring them to the appointment

MEDICAL HISTORY

Is the child regularly checked by the following:

- | | | |
|---|---------------------------------------|------------------------------------|
| <input type="checkbox"/> Medical Doctor | <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Osteopath |
| <input type="checkbox"/> Naturopath | <input type="checkbox"/> Dentist | <input type="checkbox"/> Other |

Has the child had the following childhood or other diseases?

- | | | | | |
|--------------------------------------|---|--|------------------------------------|--|
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Allergies | <input type="checkbox"/> Abdominal Pains | <input type="checkbox"/> Pertussis | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Asthma | <input type="checkbox"/> Croup | <input type="checkbox"/> Measles | <input type="checkbox"/> Meningitis |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Chronic Colds | <input type="checkbox"/> Colic | <input type="checkbox"/> Mumps | <input type="checkbox"/> Rubella |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Ear Infections | | | |

Does this child have/had braces on his/her teeth? Yes No

Does this child have any amalgam fillings? How many? Yes No

How many continuous hours is the child sleeping? _____

Is she/he well rested in the morning? Yes No

Does the child suffer from sleep difficulties? Yes No

Does the child have problems with food/eating? Yes No

Is the child a fussy eater? Yes No

Does the child have issues with hygiene/cleanliness? Yes No

Does the child complain of any ongoing physical pains? (headaches, tummy aches, muscle/joint aches, or growing pains) Yes No

Does the child suffer from dry skin, dandruff, hard skin on elbows, bumps on the outside of the arms, cracked heels, excessive thirst/urination? Yes No

Has this child received any vaccines? Yes No

If yes, please list: _____

Were there any of the following adverse reactions noticed? Yes No

- | | | |
|--|---------------------------------------|--|
| <input type="checkbox"/> Inconsolable crying | <input type="checkbox"/> High fever | <input type="checkbox"/> Sleep disruptions afterward |
| <input type="checkbox"/> Lethargy | <input type="checkbox"/> Irritability | <input type="checkbox"/> Developed allergies |

How many courses of antibiotics has this child received? _____

Has this child taken any other prescription medication in the past?

Yes

No

If yes, what were/are they? _____

Is the child exposed to a toxic environment (including passive smoking)?

Yes

No

Has the child had any serious falls, physical traumas, or physical injuries?

Yes

No

Please list: _____

SCHOOL HISTORY

Does the child like/enjoy school?

Yes

No

If not, why not? _____

Beside each subject, indicate whether it is an academic Strength or Weakness of your child:

English	S <input type="checkbox"/>	W <input type="checkbox"/>	Math	S <input type="checkbox"/>	W <input type="checkbox"/>	Music	S <input type="checkbox"/>	W <input type="checkbox"/>
History	S <input type="checkbox"/>	W <input type="checkbox"/>	Science	S <input type="checkbox"/>	W <input type="checkbox"/>	Creative Writing	S <input type="checkbox"/>	W <input type="checkbox"/>
Gym/Sports	S <input type="checkbox"/>	W <input type="checkbox"/>	Other languages	S <input type="checkbox"/>	W <input type="checkbox"/>	Other:	S <input type="checkbox"/>	W <input type="checkbox"/>
Art	S <input type="checkbox"/>	W <input type="checkbox"/>						

Beside each domain, indicate whether it seems a Strength or a Weakness in your child:

Concentration	S <input type="checkbox"/>	W <input type="checkbox"/>	Organization	S <input type="checkbox"/>	W <input type="checkbox"/>	Test Preparation	S <input type="checkbox"/>	W <input type="checkbox"/>
Handwriting	S <input type="checkbox"/>	W <input type="checkbox"/>	Planning	S <input type="checkbox"/>	W <input type="checkbox"/>	"Good" behaviour	S <input type="checkbox"/>	W <input type="checkbox"/>
Memorizing	S <input type="checkbox"/>	W <input type="checkbox"/>	Reading quickly	S <input type="checkbox"/>	W <input type="checkbox"/>	Vocabulary and Expression	S <input type="checkbox"/>	W <input type="checkbox"/>
Paying attention	S <input type="checkbox"/>	W <input type="checkbox"/>	Spelling	S <input type="checkbox"/>	W <input type="checkbox"/>	Creative Writing	S <input type="checkbox"/>	W <input type="checkbox"/>
Reading comprehension	S <input type="checkbox"/>	W <input type="checkbox"/>	Getting assignments done on time	S <input type="checkbox"/>	W <input type="checkbox"/>	Understanding concepts	S <input type="checkbox"/>	W <input type="checkbox"/>

Is getting homework done a struggle?

Yes

No

BEHAVIOUR/MENTAL HEALTH

Describe any sports or activities the child is involved in: _____

Indicate how many hours a week of "screen time" the child uses:

Computer	_____	Smart Device (phone, iPad, etc.)	_____
Computer games (DS, etc.)	_____	Television	_____



Describe the child's family relationships; with parents and siblings:

Does your child have many friends?

Yes

No

Does the child appear to excel at or struggle to build relationships with their peers? Excel Struggle Neither

If they struggle, why do you think that is?

What problems does the child have with peers, if any?

None

Bragging to peers

Being Teased

Being physically attacked

Rejected by peers

Overly physically affectionate

Being bullied

Jealous of peers

Does this child have self-esteem issues?

Yes

No

Which of the following has the child experienced in the last 12 months?

None

Mother pregnant

Parents separation/divorce

Change of school

Birth of a sibling

Move to a new home

Parent losing a job

Death of immediate family member

Serious illness/injury in immediate family

Other: _____

Do you feel that this child exhibits any of the following symptoms more often than is typical for a child of his/her age?
(Please put a check in front of any that apply)

Often touchy/easily annoyed

Often bullies/threatens

Often irritable

Often defies adult rules

Initiates physical fights

Changes in appetite

Often angry/resentful

Ever been arrested

Diminished interest

Often argues with adults

Physically cruel to others

Sleep problems

Often loses temper

Physically cruel to animals

Restlessness or slowed down

Blames other for mistakes

Motor or vocal tics

Fatigues/low energy

Deliberately annoys

Destroys property

Feels worthless

Often spiteful/vindictive

Deliberately sets fires

Becomes tearful easily

Refuses to go to school

Lies often

Often sad

Repeated nightmares

Steals

Indecisive/can't think

Unusual fears

Has run away

Thinks about death

Panic attacks

Extreme mood swings

Talks about suicide

Self-conscious/clings

Does not show emotions

Hurts self

Excessive need for reassurance

Overreacts to touch/noise

Currently uses drugs

Self-injurious behaviour

Strange or bizarre ideas

Currently drinks beer or alcohol

Worry of future events

Used drugs in the past

Used beer or alcohol in the past

Repeats certain actions

Poor social interactions

Can't stop thinking about things

Somatic complaints
(headache/stomach)

Gets upset by changes in
routine

Excessive preoccupation with objects
or ideas

Difficulty maintaining friendships

Please place a check mark in the column which best describes the child:	Not at all	Just a little	Pretty much	Very much
Often fails to give close attention to details or makes careless mistakes in schoolwork or other activities.				
Often has difficulty sustaining attention in tasks or play activities.				
Often does not seem to listen when spoken to directly.				
Often does not follow through on instructions and fails to finish schoolwork, or chores (not due to oppositional behavioural failure to understand directions).				
Often has difficulty organizing tasks and activities.				
Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)				
Often loses things necessary for tasks or activities (toys, school assignments, pencils or books)				
Is often easily distracted by extraneous stimuli				
Is often forgetful in daily activities				
Often fidgets with hands or feet or squirms in seat				
Often leaves seat in classroom or in other situation in which remaining seated is expected				
Often runs about or climbs excessively in situation where it is inappropriate (in adolescents, may be limited to subjective feelings of restlessness)				
Often has difficulty playing or engaging in leisure activities quietly				
Is often "on the go" or often acts as if "driven by a motor"				
Often talks excessively				
Often blurts out answers before questions have been completed				
Often has difficulty waiting turn				
Often interrupts or intrudes on others (butts into conversations or games)				

REASON FOR ASSESSMENT

Please describe in your own words what concerns you have about this child. Also, please add any additional information that you feel is important and may be helpful in our assessment.

What specific **question** do you have that you hope an evaluation will answer?

Your name _____ Relationship to child _____

Date: ___/___/___